RHODE ISLAND
DEPARTMENT OF HEALTH

Immunize For Life Program

2007 Agreement to Participate

Rhode Island Department of Health
Three Capitol Hill
Providence, RI 02908-5094

www.health.ri.gov

Immunize For Life

2007 Annual Enrollment (07/01/2007 – 06/30/2008)

The 2007 Agreement to Participate is the second part of enrolling your practice/facility in the Department of Health (HEALTH) *Immunize For Life* program.

Before completing the 2007 Agreement to Participate, make sure you have:

- Completed the Practice/Facility Enrollment for *Immunize For Life*.
- Printed a copy of the Congratulations! page.
- Recorded your Practice/Facility Confirmation Number.

Included are:

- Immunization Resource Information (required and recommended)
- **2007 Agreement to Participate - *Immunize For Life* Program**

Return completed and signed 2007 Agreement to Participate to:

Mail:
Rhode Island Department of Health
Immunize For Life Program
3 Capitol Hill, Room 302
Providence, RI 02908

Fax:
(401) 222-1442
Attention: *Immunize For Life* Program

For questions, contact the *Immunize for Life* program at 401.222.7876.

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Immunization Resource Information

Required documents

A copy of each of the following documents must be maintained at the practice for use and/or reference.
(Documents are available for download at www.health.ri.gov)

Vaccine Order Form

It's Federal Law! VIS

Current VISs for handout to patients

Checklist for Safe Vaccine Storage and Handling

Notice of Vaccine Adverse Events Reporting System (VAERS)

National Vaccine Injury Compensation Program (VICP)

Additional Resources

The following organizations have information that may be useful for your practice/facility:

Centers for Disease Control & Prevention (CDC) - http://www.cdc.gov/

National Immunization Program (NIP) - http://www.cdc.gov/nip/default.htm

Immunization Action Coalition (IAC) - http://www.immunize.org/

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Immunize For Life – 2007 Agreement to Participate

To participate in the *Immunize For Life* Program and receive state-supplied vaccine at no cost, I agree to the following conditions, on behalf of myself and all the practitioners, nurses and others associated within the medical office, group practice, managed care organization, community/migrant/rural clinic, health department, or health delivery facility of which I am the Medical Director/Lead Physician or equivalent. Our practice/facility and staff agrees to:

1. Enroll in the *Immunize for Life* Program annually. Enrollment is for a 12-month period (July 1-June 30) and must be completed by June 30th for the following year.
2. Comply with the Standards for Immunization Practices and the Adult Immunization Schedule, as recommended by the Advisory Committee on Immunization Practices (ACIP) unless a) in my medical judgment, and in accordance with accepted medical practice, I deem such compliance to be medically inappropriate; or b) the particular requirement contradicts the law in my state pertaining to immunization exemptions.
3. Keep a current copy of each of the following documents at the practice/facility for use and/or reference: HEALTH Vaccine Order Form**;** It's Federal Law!; Current VISs for distribution to patients; Vaccine Storage and Handling Checklist; notice of Vaccine Adverse Events Reporting System (VAERS) and notice of National Vaccine Injury Compensation Program (VICP).
4. Comply with federal law and distribute the most current Vaccine Information Statements (VIS) before administering vaccine(s).
5. Maintain an Immunization Record of each vaccine given including the date administered, site, lot number, manufacturer, the publication date on the VIS, the date the VIS was given, and the signature of the person administering the vaccine.
6. Report all Vaccine Adverse Events.
7. Comply with the state's requirements for proper Vaccine Storage and Handling. This includes, but is not limited to: approved temperature monitoring equipment for refrigerator, documentation of twice daily refrigerator temperature checks on a Temperature Log, and records of actions taken for refrigerator temperatures outside recommended range.
8. Accommodate any state request for an on-site inspection of patient vaccine records, vaccine inventory and/or storage facilities within 60 days of the initial request.
9. Comply with the state's vaccine ordering procedure.
10. Not impose a charge to patients for the cost of any state-supplied vaccine.
11. Be accountable for all doses of vaccine and submit a reimbursement claim or documentation of uninsured status for the administration of each dose of vaccine. HEALTH will allow a 5% waste margin to each provider/facility. Any wastage of more than the 5% margin will be deemed excessive and will require payment to HEALTH for the vaccine.
12. Acknowledge that any future program enrollments will be denied until all outstanding financial obligations from the previous year(s) are paid in full to HEALTH.
13. Notify HEALTH should any of the following information for your practice/facility change: practice/facility name, address, phone or fax number, office manager, vaccine contact, lead physician or delivery information.
14. Attend training/information/technical assistance session as required by HEALTH.

This agreement is binding and will remain in effect until: (1) HEALTH terminates this agreement, at any time, for failure to comply with the program requirements (2) the practice terminates this agreement for reasons determined by the Medical Director of the practice or (3) there is a change of the Medical Director (Lead Physician) and/or entity name, or failure to renew annual enrollment.

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Medical Director / Lead Physician (Print Name) Enrollment Application On-line Confirmation Number

X_____ **X**_____

Medical Director / Lead Physician Signature Date HEALTH Authorized Agent Signature

Practice/Facility Name:_____